Statement of Patrick J. Howard

Principal, State Health Care Practice Leader

Deloitte Consulting LLP

Before

The Michigan House Health Policy Committee

December 1, 2011

Good morning Madam Chair and members of the Committee:

Thank you for the invitation to appear before you today to offer a national perspective on health insurance exchanges, to share the experiences of other states, and to outline the pros and cons of the exchange options facing the state governments.

I appreciate the opportunity to provide testimony on a subject in which I have been deeply involved. As the State Health Care Practice Leader for Deloitte Consulting LLP (Deloitte Consulting), I have spent the past two decades providing information technology and business process services to numerous states, including Michigan. I have spent more than 15 years working directly in the State Health arena and with peers in private sector industries that support business-to-business and consumer-to-business exchanges designed to improve customer satisfaction and reduce administrative costs.

I am proud to represent a firm with over 40 years of experience helping states implement and manage complex programs to protect and promote the safety and well-being of families. Deloitte Consulting is consistently ranked a national leader in health and human services consulting. Our journey assisting states began in the 1970's and since then we have delivered projects in almost every state. Relevant to this conversation we have delivered eligibility systems to 23 states and our self-service portal solution to 19 states which provides us deep experience in interpreting and implementing program policy. In the State of Michigan we have worked with the state to implement and support Bridges and MiBridges, work we are currently doing today.

In addition, the firm's Center for Health Solutions produces timely reports that are objective, data-driven and reflective of the diversity of viewpoints on trends and issues affecting health care. The Center's research is focused in three major areas: (1) health policy and health reforms in the U.S. health care system; (2) disruptive innovations that result in new solutions to improve efficiency and effectiveness; and (3) consumerism, incorporating how the end users of health care services think and behave. The committee might be interested in our recently released 2011 survey of Health Care consumers, which I would be happy to share with you.

It is my intention today that by sharing my testimony, Deloitte Consulting's experience, and our firm's research will give you a better understanding of the options before you and the potential impact of health reform on Michigan.

As you may know, the Affordable Care Act (ACA) and its companion, the Health Care and Education Reconciliation Act (HCERA) of 2010, referred to collectively as "Health Reform", became law last year and presented state governments with the responsibility of determining what role health insurance exchanges will play in the context of health reform. This is no small task.

Health reform is complex and far-reaching, with a goal of insuring an additional 32 million people. The legislation is also 10 times as long as the original welfare reform bill passed in 1996, and 39 times longer than the Social Security Act passed in 1935, running over 2,500 pages and containing over 3,000 requirements and 300 business processes.

Despite the intense debate over health care reform and pending court challenges, states face looming federal deadlines that must be considered as they weigh the pros and cons of establishing state health insurance exchanges. Typically, states would assess new federal regulations, translate them into business requirements and then implement the technology to support them. In this case, however, the federal deadlines have caused the emphasis to be put on the technology and that is driving many decisions around exchanges. In reality, the business model you choose to implement still needs to be driving the technology decisions that you make and the overall model you select.

Regardless of whether you decide to establish a Michigan exchange or opt to let the Federal government manage the exchange, there are still plenty of activities that must be accomplished in order to meet the federal timelines.

Today I will talk about the types of exchanges many states are considering, the technical building blocks that are necessary for an exchange, the pros and cons I see of the state and federal models, and the important timelines and other factors that may influence your decision.

The following table outlines the key points I will make in my testimony.

Topic	Key Points
1. Exchange Operating Models	• Information Aggregator • Retail-Oriented Exchange • Guided Exchange • Market Curator
2. Overarching Considerations	• Navigator Program • Handling "churn" between programs • Security & Privacy Concerns
3. Technology Options	• Existing functions to leverage
4. Building a State Exchange	• Leverage existing staff, technology and business processes • Supporting a path to self-sufficiency • Supporting local stakeholder concerns

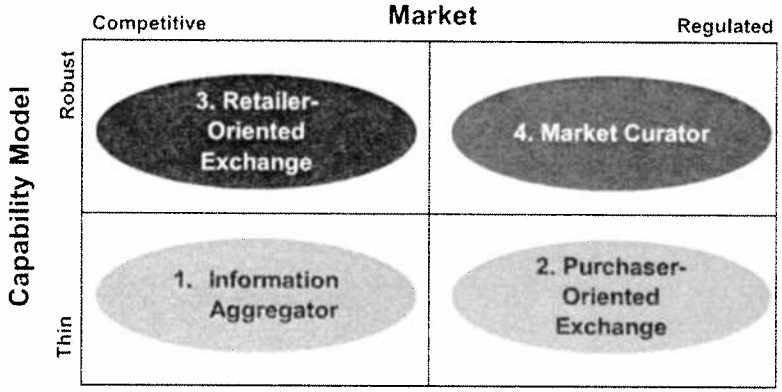
Topic	Key Points
5. Use the Federal Exchange	• Opportunities • Technology limitations • Programmatic limitations
6. Timeline	• Level 1 Establishment Grant • Level 2 Establishment Grant

1. Exchange Operating Models

While health reform is prescriptive in some of the provisions, states are given significant flexibility in how they choose to address some of the requirements of a health insurance exchange. Most states that are planning to implement their own exchanges have leaned toward one of the following four main operating models: Information Aggregator, Retail-oriented Exchange, Guided Exchange, or Market Curator. The models are depicted on the following page.

Diagram 1. Health Insurance Exchanges – Four Potential Models

Health Insurance Exchanges — Four potential models



Exchange Models

1. Information Aggregator	2. Purchaser-Oriented Exchange	3. Retailer-Oriented Exchange	4. Market Curator
• Delivers minimum capabilities to meet requirements of PPACA • Impartial aggregator of information on health plan products and quality information • Provides structure to allow health plan comparisons • Accountability of the product or service delivered is primarily left to the plan who actually provides the service	• Limits carriers available on the Exchange through a competitive selection process • Products may also be standardized • More prescriptive mandates and regulatory oversight over the market • Functions "owned" by the Exchange are minimal with basic tools and plan comparison information available	• Creates a retail shopping experience with robust service capabilities (e.g. ability to shop by price or benefits needs) and "shop to enroll" transaction scope • Offers a broad range of products offered with variation in price and design • Provides education, outreach, and technical assistance for consumers • Provides information and enrollment assistance	• Creates a robust end-to-end consumer experience from shopping to enrolling • Exchange responsible for selecting the products that it feels are the best fit for customers, organizing them and maintaining product data files • Extensive suite of consumer and member management services, ranging from initial enrollment and billing to ongoing maintenance transactions

The Information Aggregator model delivers the minimum capabilities to meet the requirements of health reform. This model aims to be an impartial aggregator of information on health plan products and quality and provides structure to allow plan design and price comparison. The downside is it provides limited support to citizens as they shop for health insurance. Utah has a similar model in which they provide a list of options for the consumer but do not provide comparison functionality.

The Retail-oriented Exchange model creates a retail shopping experience with robust service capabilities, for example, the ability to shop by price or benefit needs. This model offers a broad range of products varying in price and design, and provides education, outreach, and technical help for consumers, as well as enrollment information and assistance. This model of the exchange allows for a competitive market with robust shopping experience and may be compared to shopping experiences by sites like Orbitz or Amazon. However, unlike the next two options, it does not limit the list of potential plans and therefore an individual may have to sort through numerous offerings to find their "best" match.

The Guided Exchange model limits the carriers available on the exchange through a competitive selection process. It may require standardized products and have more prescriptive mandates and regulatory oversight over the marketplace. This is expected to be an interim model for states as they build out additional exchange capabilities and ultimately achieve a model more closely aligned with the Market Curator model.

The Market Curator model creates a robust, end-to-end consumer experience from shopping to enrolling for individuals, employers and/or employees. It may also opt to limit carriers through a competitive selection process. This model aims to assist users in selecting products that best fit their needs, organizes them, and maintains product data files. This model would also provide extensive member management services such as initial enrollment and billing.

At the present time no one exchange model seems to be the most prevalent.

2. Overarching Considerations

There are several other considerations that states have taken into account as they consider options for health insurance exchanges.

Navigator program

The Navigator program is meant to conduct public education activities, distribute information concerning enrollment in plans and subsidy availability, facilitate enrollment in plans, and provide referrals to health insurance consumer assistance offices. States have significant flexibility in the degree to which the Navigator program is leveraged and how Navigators would operate and be compensated.

Handling "churn" between programs

One of the most challenging issues for Medicaid managed care organizations (MCOs) is membership "churn" – losing members because of lost eligibility. One major plan reports the average enrollment time for its TANF members to be seven months. Another plan's internal study indicated that only one third of its TANF members remained with the plan for two years. Churn makes it difficult for MCO care management and wellness/prevention programs to achieve sustainable behavior change. We anticipate that there is significant risk of churn as individuals move between Medicaid, children's health insurance program (CHIP) and subsidized health insurance. There are four options for mitigating the effects of this "churn":

- Restrict plans selling to subsidized exchange populations to MCOs serving Medicaid programs
- Execute state Basic Health Plan option and use Medicaid MCOs
- Encourage Medicaid MCOs to sell individual and small group policies on the exchange
- Encourage all insurers selling products on the exchange to also participate in the Medicaid managed care program

Security & Privacy Concerns

Security and privacy is another important consideration. Health insurance exchanges will dramatically increase the amount of personal and health information collected and managed by states. A recent report on cyber security by Deloitte and the National Association of State CIOs (NASCIO) revealed that many states are not adequately protecting the data they maintain about their citizens. NASCIO's 2009 study found that government agencies were responsible for one-fifth (20%) of the data breaches reported in the country. States can effectively manage the privacy and security of their data by taking a risk-based approach and deploying proven security practices and technologies to mitigate the risk. It is important for states take proactive measures to be compliant with state and federal regulations.

For example, HIPAA and HITECH provisions require safeguarding privacy and security of the health information and carry penalties for data breaches and violations. The use of Federal Tax information as part of the health insurance exchange requires the system to follow stringent Federal IRS 1075 publication requirements – that prescribes how the individual's tax information can be used and what level of audit trails of access are to be maintained.

While these requirements may appear daunting and onerous, the states have addressed the privacy and security aspects by including them as part of the planning and funding requests to the federal government. The alternative – adding security after a data breach or an incident occurs – is expensive, painful and impacts public trust.

3. Technology Options

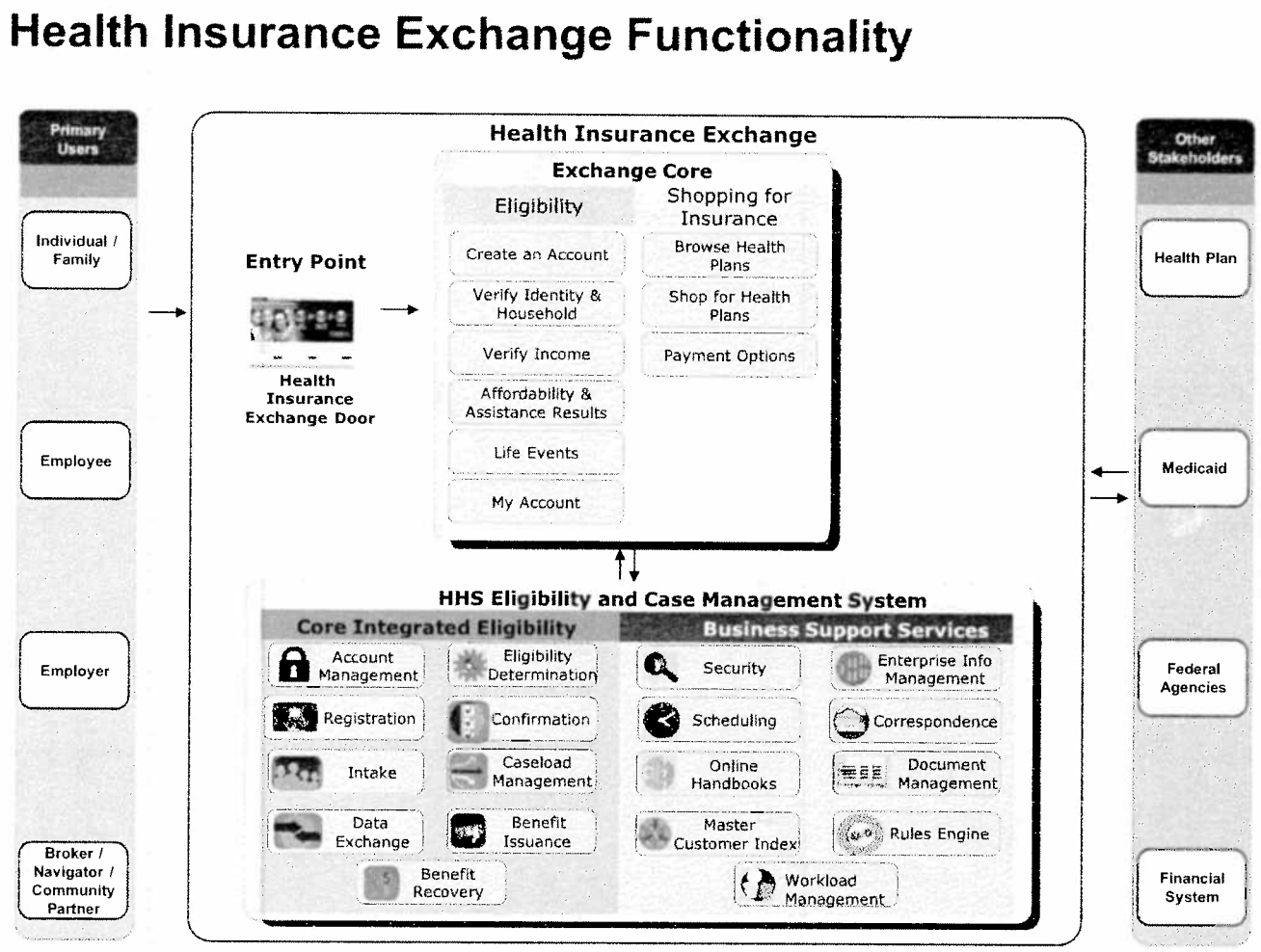
When considering technology choices, an evaluation of each exchange option in addition to an understanding of existing assets that can be leveraged is helpful in determining the best course of action.

Exchanges may offer the ability for individuals to create an account, verify their income and household information, and determine eligibility as well as shop for a qualified health plan, complete an application and capture payment information. As noted in the image below, several of these components can leverage existing functionality. By doing so, states may be able to control costs and keep a similar feel between the health insurance exchange and their integrated eligibility solution.

When it comes to a health insurance exchange as the Federal legislation currently exists, there are two options for states: build a state-specific exchange or allow the Federal government to run the exchange. There are pros and cons to consider for each option, but both options require quick decisions and action by the State in order to meet federal deadlines.

The diagram on the following page depicts the functionality required for an exchange.

Diagram 2. Health Insurance Exchange Functionality



Page 2 of 3 – Supporting Documentation
Statement of Patrick J. Howard, Principal, State Health Care Practice Leader, Deloitte Consulting LLP before the Michigan House Health Policy Committee – December 1, 2011

4. Building a State Exchange

Making the best use of existing staff, technology and business processes

An important consideration for a state-specific exchange is the ability of the state to leverage existing production proven assets which could improve efficiencies, shorten implementation timeframes, streamline functionality, and reduce risk. For example, states can leverage existing websites that allows state residents to screens for eligibility programs by expanding it to allow citizens to apply for health insurance. Additionally the existing the eligibility determination module may be leveraged to determine the tax subsidy.

The Federal guidance to states is to leverage existing technology assets that can be extended to support ACA implementation. The State of Michigan is in a unique starting position with modernized technology for Medicaid eligibility, CHIP, and a self-service portal where citizens can apply online for health and human services benefits. These technologies can be extended for the establishment and operation of a Michigan exchange.

The State of Michigan has invested in Bridges since 2006 as its statewide system to perform Medicaid eligibility; this includes 49 Medicaid categories, including CHIP screening and referal. A large portion of these Medicaid categories will continue even after the health care reform's simplified Medicaid rules are applied.

Over the last two years the State has extended Bridges through the on-line self-service portal, called MiBridges, allowing citizens the ability to determine the programs they are eligible for and apply on-line. The internet portal can be extended as a standalone exchange portal, or a shared "no-wrong door" portal for all health and human services offered in the State.

The time and cost of making the required changes to existing technology assets will be significantly less than redeveloping what these systems do in any other existing system or developing new systems altogether. This approach would be fully consistent with Federal guidance.

An example of how this could be beneficial would include "split families" where some members are Medicaid-eligible while others would purchase individual coverage (with a potential federal tax credit to support some of the cost). By leveraging existing state technology systems, the design could be built to accommodate the family's selection in a single process rather than requiring them to go through several steps to obtain coverage.

Supporting a Path to Self Sufficiency

Building a state based exchange has also been considered by some states to be an opportunity to help individuals on a path to self-sufficiency. Consider an individual that comes to the exchange to apply for Medicaid for their family and is found eligible. Over time their income increases, their children are eligible for CHIP and they are eligible for a tax credit. Then they gain employment with a small employer who also participates in the exchange. Throughout their path to self-sufficiency, they are supported by the state based exchange. This experience

can be branded such that the association with welfare is removed and that a connection to the private health care market can be fostered. At the same time, the state can leverage the Medicaid eligibility technology that has been proven to be secure, scalable and reliable.

Supporting local stakeholder Concerns

As part of health reform states are now being asked strike a new balance that serves the uninsured while complying with the provisions of health reform. A state-specific Exchange will enable states to give key stakeholders to chance to express their views on various health care options and for you to address their concerns. This option will also allow states the opportunity to provide their broker community a seat at the table in designing your exchange.

5. Use the Federal Exchange

Another option for states is to let the federal government provide the exchange solution. While the legislation indicates a preference for states to design and implement their own exchanges, a federal exchange will be developed for those states that choose not to or that cannot meet the federal timelines.

Using the federal exchange allows states to defer the technical design and implementation and the operations costs of the exchange to the federal government. It also provides the state the option of continuing to be involved in the plan certification and customer service components of the exchange if they choose.

States have raised two primary concerns relative to using the federal exchange: technology limitations and programmatic limitations.

Technology Limitations

States that opt to use the federal exchange will be required to use a generic (in the sense of built for all states versus one state) solution that was built at the Federal level. While it is likely that the solution will accept feedback from those states that plan to use the Federal Exchange, the ultimate design will likely represent common needs across states and be a compromise between competing requests.

Programmatic Limitations

The federal exchange will be managed centrally, and the federal government will perform an initial Medicaid determination, with the state providing final determinations. Initial reaction is that this gives states more control; however, the details of this approach are not yet known and may cause complexity in future programmatic decisions as the two rule basis need to be kept in sync. Also, the client may face confusion as they move between the two systems.

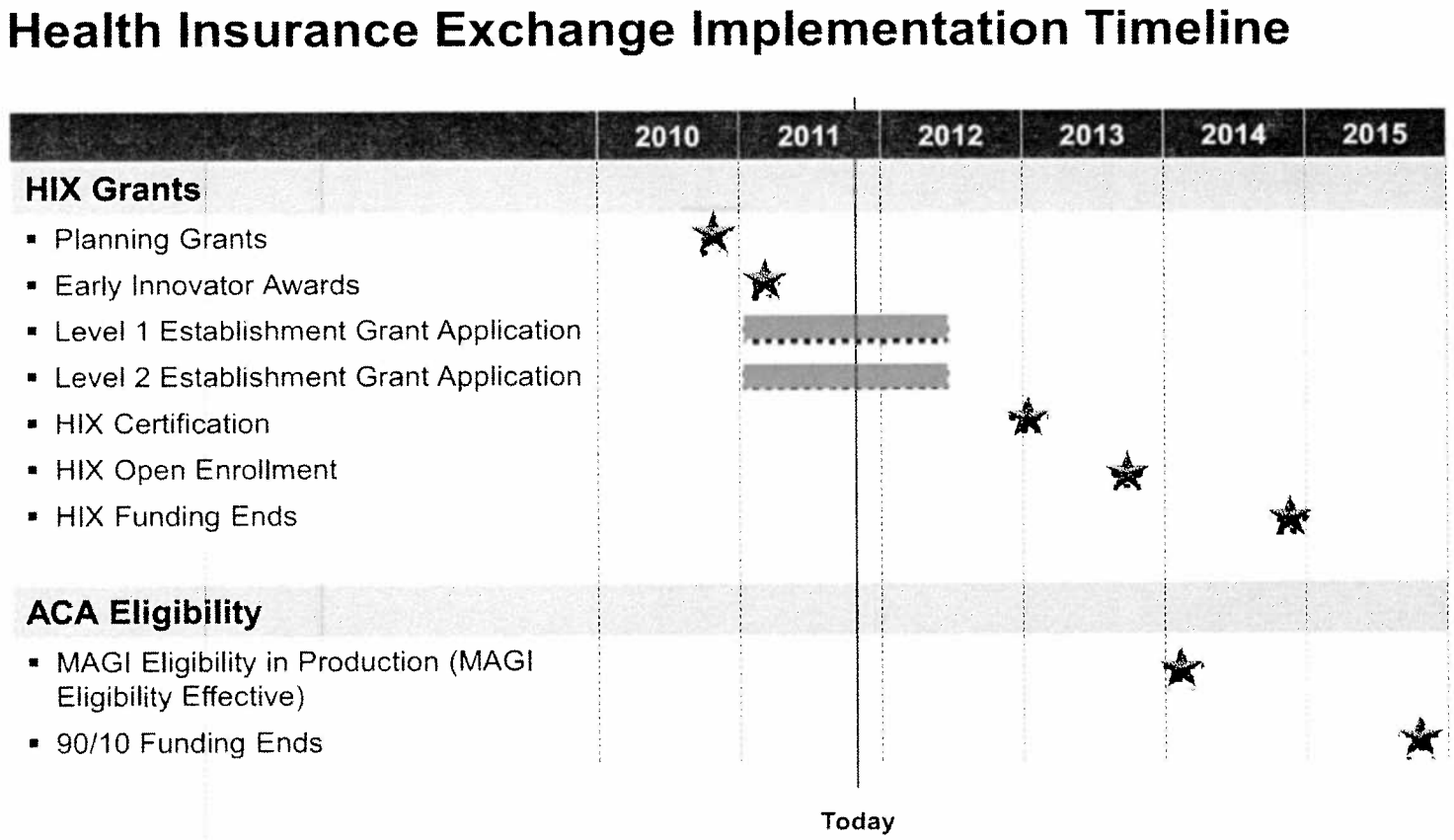
While the federal exchange may provide the solution for a component of health reform, there are several other components which the state must address which include: reinsurance

oversight, risk adjustment, and risk corridors. With the first two, they are run as part of the Federal Exchange, but states may also opt to operate them internally or contract with another entity in order to comply with regulations.

6. Timeline

Many, or most of you, may be aware of the impending federal deadlines. The timeline on the following page pictorially illustrates the major milestones.

Diagram 3. Federal Timeline and Major Milestones for Establishing a Health Insurance Exchange



One of the most pressing deadlines is for requesting a Level 1 Establishment Grant. Level 1 establishment grants provide states 100% federal funding for planning and designing the state's approach to health reform. Requesting a level 1 establishment grant does not commit the state to developing a state based exchange, rather it provides the state with the ability to continue to explore that option.

The new deadline, just released on Tuesday this week, for requesting a Level 1 Establishment Grant is now June 29, 2012. I understand that Michigan just received federal approval for its Level 1 Establishment Grant this week.

The Level 2 Establishment Grant requires that a state has enabling legislation and will fund the development of the exchange and the first year of operations. The deadline for applying for this grant is June 29, 2012.

In addition, the Affordable Care Act calls for significant changes to the way that Medicaid eligibility is determined for a significant portion of the Medicaid population. The new income standard is known as the modified adjusted gross income (MAGI) test and must be implemented by January 1, 2014. These changes require detailed modifications to existing eligibility and screening systems. This will take time to implement and will need to occur regardless of a state's approach to the health insurance exchange.

These deadlines are aggressive and fast approaching. Many states are questioning whether these deadlines will get extended, however there is no guarantee that they will. Therefore a number of states have opted for building a plan to meet these deadlines to ensure that the state can build the exchange that is best suited for its constituents.

7. Conclusion

Whether you will support or oppose health care reform and the implementation of a State of Michigan exchange, the issues I have discussed today are ones that states are confronting as they determine the type of health insurance exchange that is best for them. The choice is yours. Whatever you decide, there are pending deadlines that have a significant impact on Michigan taxpayers and the health insurance options available to your consumers.

Thank you for the privilege to testify before your committee Madam Chair, and for the opportunity to share Deloitte Consulting's public sector health and human services expertise. I am happy to answer questions you may have.

Contact Information

Clayton Frick

Deloitte Services LP

(312) 486-2816

cfrick@deloitte.com

Brett H. Henderson

Kelley Cawthorne

(517) 371-1400

bhenderson@kelley-cawthorne.com